State Guide to Federal Health Reform for Massachusetts Employers

Second Edition

Governor Deval Patrick
Lieutenant Governor Timothy P. Murray

JudyAnn Bigby, M.D.
Secretary, Executive Office of Health and Human Services

August 2011

Table of Contents

Introduction

President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010. This federal health reform law makes changes across the health care system in the United States. These changes include:

- An individual mandate (similar to the Massachusetts mandate)
- New responsibilities and opportunities for employers
- Expansions of existing public programs like Medicaid (MassHealth)
- Subsidies to help low and middle- income people afford health insurance
- Tax changes to the financing of health care
- Health insurance exchanges like the Massachusetts Health Connector
- New minimum benefits
- Protections for health insurance consumers
- Savings and efficiencies in Medicare and Medicaid
- Measurement and rewards for high-quality, effective care
- Wellness and prevention programs
- Support for a well-equipped health care workforce

Massachusetts employers are well ahead of those in other states. They have been key partners in Massachusetts' own health reform, and are among the most generous and engaged when it comes to offering and promoting health coverage.

About this Guide

A working group of state agencies, convened by Executive Office of Health and Human Services Secretary JudyAnn Bigby, produced the first edition of this guide in October 2010. Content was provided by the Division of Insurance, the Health Connector, and the Division of Health Care Finance and Policy. The guide provides a high level overview of the federal health reform law and how it may impact Massachusetts employers. It also provides suggestions for where to find more information. The guide is not intended and should not be construed as advice to employers regarding compliance with the federal health reform law.

The information in this guide is set forth in chronological order based on when programs and rules go into effect.

Second Edition Updates

This edition of the guide provides updated information for employers regarding the federal health reform law. Since October 2010, statutory and regulatory changes, as well as additional federal guidance have clarified the potential impact of federal health reform on Massachusetts employers. Key updates from the first edition are included below.

- The Free Choice Voucher provision of PPACA was repealed on April 15, 2011. The provision would have required employers that offer insurance and contribute toward health insurance coverage to provide "free choice vouchers" equal to the amount the employer would have contributed to its own health plan to employees who qualify.
- As of July 2011, Congress has not appropriated funds for the small employer wellness programs. See more information about wellness programs on page 9.
- The Early Retiree Reinsurance Program, which provides reinsurance to self-funded and fully insured retiree health plans, is no longer accepting new applications. Current participants can still submit claims. See more information on the Early Retiree Reinsurance Program on page 10.
- The Department of Labor published a notice and fact sheet regarding the requirement that all employers provide reasonable break time for nursing mothers. The Department clarified that hardship exemptions will be determined on a case-by-case basis and will place the burden of proof on the employer to prove hardship. See more information on the nursing mothers provision on page 12.
- The Internal Revenue Service (IRS) changed its position on the prohibition on the use of debit card systems to purchase over-the-counter medicines with a prescription. The IRS is currently permitting taxpayers to continue using Flexible Spending Account (FSA) and Health Reimbursement Account (HRA) debit card systems to purchase over-the-counter medicines with a prescription. The IRS granted additional relief to small employers who file fewer than 250 W-2 forms by exempting them from the requirement to report the annual cost of employer subsidized health coverage on an employee's W-2 until further notice. All other employers will be required to report health coverage costs in 2012. See more information on IRS tax treatment changes and reporting on page 21.

Federal Health Reform Policies that Affect Massachusetts Employers

1. Small Business Tax Credit

New federal tax credits are available to help small businesses with low and middle-income workers pay for the cost of health insurance.

A small business health care tax credit is available to small employers that pay at least half of the cost of individual coverage for their employees. This federal credit is designed to help small businesses and tax-exempt organizations that primarily employ low and middle-income workers. This tax credit is meant to offset some of the costs associated with offering health insurance coverage and is available to both qualified employers who currently offer coverage and those that want to begin offering coverage. It supports employers' ability to grow and create new jobs. A July 2010 Families USA and the Small Business Majority report estimates that 81,300 small businesses in Massachusetts could be eligible for the small business health care tax credit.

Credits for Tax Years 2010 to 2013

- Eligible small employers may qualify for a credit of up to 35 percent of the premiums they paid.
- Eligible tax-exempt organizations may qualify for a credit of up to 25 percent of the premiums they paid.

The maximum credit goes to employers with ten or fewer full-time equivalent (FTE) employees who earn average annual wages of $25,000 or less.[1] Partial credits are available to employers with up to 25 FTEs who earn average annual wages up to $50,000.

The eligibility rules take into account the number of FTEs, not the number of employees. Businesses with part-time workers may qualify even if they employ more than 25 people.

Eligible small businesses can claim the credit as part of the general business credit, starting with the 2010 tax return they file in 2011 by using new IRS Form 8941.[2] Tax-exempt organizations will claim the credit on IRS Form 990-T.

Credits for Tax Years 2014 and Beyond

[1] Under PPACA, the number of employer full-time equivalent employees (FTEs) during a tax year is equal to the total number of hours for which employees were paid wages by the employer divided by 2,080. Only the first 2,080 hours of each employee's wages are taken into account, hours in excess of this are not counted. This is different from the Massachusetts definition of FTE for the purposes of Fair Share Contribution under Massachusetts Health Reform, which is based on 35 hours worked per week.

[2] http://www.irs.gov/pub/irs-dft/f8941--dft.pdf

In 2014, the maximum tax credit will increase to 50 percent but will only be available to employers who purchase health coverage for their employees through an exchange like Massachusetts Health Connector.

Effective Date

March 23, 2010.

For More Information

The IRS has resources to help employers determine their eligibility and obtain the Small Business Tax Credit.

- YouTube Video: http://www.youtube.com/watch?v=zDgHE3ho2fQ
- One-page flyer: http://www.irs.gov/pub/newsroom/taxcreditflyer.pdf
- FAQ: http://www.irs.gov/newsroom/article/0,,id=220839,00.html
- 3-step Guide: http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf
- Detailed Guidelines: http://www.irs.gov/pub/irs-drop/n-10-44.pdf

The Health Connector has a "tax credit calculator" on its website that provides preliminary estimates for eligibility and savings.

- Calculator Link: http://www.mahealthconnector.org under "Employers" Tab.

2. Grants for Small Employer Wellness Programs

Funding is available to help small businesses offer programs to keep employees healthy.

For 2011 through 2015, $200 million has been authorized for grants to help small employers across the United States provide workplace wellness programs to their employees.
As of July 2011, Congress has not appropriated the funds for this program.

Eligibility

Small employers with fewer than 100 employees working 25 hours or more per week are eligible.[3] Funding will be available only to employers that did not have a wellness program in place as of March 23, 2010.

How to Apply

Guidance on how and when employers can apply is pending. Employers will need to have a well-defined plan for implementing a wellness program. The program should promote health awareness initiatives like preventive screenings and health risk assessments.

Effective Date

March 23, 2010.

[3] Note that employees here are based on employees who work 25 hours or more per week rather than FTEs.

3. Early Retiree Reinsurance Program

Employers may receive financial assistance to help pay for the expensive medical costs of early retirees.

Employers with early retiree plans will be able to apply for reinsurance for early retirees who are at least 55 and not eligible for Medicare. Reinsurance is insurance purchased by insurers or employers for financial protection in the event of very expensive claims. Reinsurance transfers some of the risk from the insurer to the reinsurer. The percentage of U.S. large firms providing retiree coverage has dropped from 66 percent in 1988 to 31 percent in 2008, due mostly to rising premium costs. Employers may qualify for reimbursement of 80% of claims between $15,000 and $90,000 incurred within a particular plan year. The program provides a total of $5 billion in financial assistance to employers who qualify.

Eligibility

Both self-funded and insured plans are eligible, including those offered by private entities, state and local governments, non-profits, religious entities, unions, and other employers. There is no employer size requirement associated with eligibility. Employers must have at least $15,000 in early retiree health care claims.

New Enrollment Closed

Effective May 6, 2011, the Early Retiree Reinsurance Program (ERRP) is no longer accepting new applications. This decision was based on the availability of remaining appropriated ERRP funds and the rate at which the program has been disbursing reimbursement. It is not based on the projected amounts of ERRP reimbursements that applicants listed in their ERRP applications. Should circumstances related to the availability of ERRP funding change, the federal government may decide it is appropriate to resume accepting ERRP applications.

How It Works

Reinsurance reimbursements are provided to employers that are accepted into the program. Reimbursements cover:

- Medical claims for retirees age 55 and older who are not eligible for Medicare, as well as their spouses, surviving spouses, and dependents.
- Many medical, surgical, hospital, prescription drug, and other benefits between $15,000 and $90,000.

Claims incurred before June 1, 2010 are not eligible for reimbursement, but do count toward the $15,000 qualifying threshold. Only medical expenses incurred after June 1, 2010 are eligible for reimbursement.

The Early Retiree Reinsurance Program ends when either funding runs out or on January 1, 2014, when early retirees will be able to choose coverage options through an exchange.

Effective Date

March 23, 2010.

For More Information

- New Early Retiree Reinsurance website: http://www.ERRP.gov
- New Early Retiree Reinsurance hotline: 877-574-3777

4. Reasonable Break Time and Space for Nursing Mothers

Employers must offer adequate break time and space for breastfeeding employees.

Breastfeeding employees must be allowed "reasonable break time" each time an employee needs to express milk. Employers are required to provide "a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk." These accommodations must be provided to the breastfeeding employee until the child's first birthday. This requirement applies to employers of all sizes.

The Department of Labor released a notice containing a "preliminary interpretation" of the law and asked for comments. At this time, the Department does not expect to issue regulations on this provision.

In its notice, the Department said that it expects that nursing mothers will typically need two to three breaks to express milk during an eight hour shift, with longer shifts requiring additional breaks.

Exemptions

Employers with 50 or fewer employees may seek an exemption.[4] The employer bears the burden of proof to show that compliance with the nursing mothers break time provision would impose an undue hardship on the employer. Employers seeking exemption must show that this requirement would create "an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business." At this time, the Department of Labor will not grant prospective undue hardship exemptions to employers.

Effective Date

March 23, 2010.

For More Information

- Department of Labor Website on Nursing Mothers Provision: http://www.dol.gov/whd/nursingmothers/
- Department of Labor "Preliminary Interpretation" Guidance: http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=24540&AgencyId=14

[4] For this provision, an employee is defined as "any individual employed by an employer," and must include all full-time and part-time employees and employees from all work sites.

- Department of Labor Fact Sheet: http://www.dol.gov/whd/regs/compliance/whdfs73.pdf
- Federal Health and Human Services Website on Workplace Nursing Resources: http://www.womenshealth.gov/breastfeeding/government-programs/business-case-for-breastfeeding/index.cfm

5. Automatic Enrollment for Employees of Large Firms

Employers with more than 200 full-time employees that offer health coverage must automatically enroll new full-time employees in a plan.

New full-time employees must be enrolled in an employer's plan automatically, pending a lawful waiting period. Current employees will continue to remain enrolled. The automatic enrollment process must provide adequate notice and the opportunity for an employee to opt out of any coverage.

The Department of Labor is required to issue regulations on this provision. The Department has not yet issued regulations.

Effective Date

Effective upon issuance of guidance by the Department of Labor.

6. Insurance Reforms

The federal health reform law makes several changes to the health insurance market.

Some federal health insurance reforms do not take effect until 2014. The focus here is primarily on some early changes that have already gone into effect. Many of the new federal requirements have already been law in Massachusetts for some time.

Where applicable, this guide notes whether the new requirement will constitute a change in the way that health plans are administered in Massachusetts. In general, the Massachusetts insurance laws described in this section do not apply to self-funded plans.[5] The insurance reforms in national health reform that are described in this section of the guide apply to both fully insured and self-funded plans.

Limits on Lifetime Benefits

A health plan cannot limit the dollar value of the "essential health benefits" that an enrollee can receive *in a lifetime*.

- **How This Affects Massachusetts**: Most health plans sold in Massachusetts do not have lifetime limits. Federal law now says that new or existing plans cannot impose lifetime limits on essential health benefits. Benefits that are not considered essential health benefits however may be subject to lifetime limits.

In the essential health benefits package, the following services must be covered: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services (including chronic disease management), and pediatric services (including oral and vision care).

The full definition of essential health benefits has not yet been issued. Until the full definition is issued, the enforcing agencies will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits."

Health plans may provide benefits in addition to the services included in the essential health benefits package.

Limits on Annual Benefits

[5] However, Massachusetts' Minimum Creditable Coverage (MCC) requirement, requiring Massachusetts residents to meet certain essential health benefits to be considered insured and avoid tax penalties, applies to all individuals, including individuals enrolled in self-funded plans. Health insurers licensed in Massachusetts must let consumers know if their plans meet these standards.

A health plan can only have restricted limits on the dollar value of essential health benefits that an enrollee can receive *in a year*.

- **How This Affects Massachusetts**: With some notable exceptions such as Young Adult Plans or Student Health Insurance Plans, health plans with annual caps do not meet the current Massachusetts' Minimum Creditable Coverage (MCC) regulations developed under Massachusetts health reform. Those state regulations are available at www.MAhealthconnector.org under the Health Care Reform tab, then "Key Decisions."

Beginning September 23, 2010, $750,000 is the lowest annual limit a health plan can impose on "essential health benefits" in the U.S. The limit will increase each year until January 1, 2014, when annual limits will be eliminated.

The rules apply to new and existing plans. Annual caps will be allowed on benefits that are not considered essential health benefits. Plans must make "good faith efforts" to comply with a "reasonable definition" of essential health benefits as it relates to the lifetime cap requirement.

Health plans may be able to seek a waiver of these federal requirements.

Rescission

A health plan cannot retroactively drop an insured person from a plan, except in case of fraud, intentional misrepresentation of a material fact, or for nonpayment of premium.

- **How This Affects Massachusetts**: Massachusetts already prohibits retroactive cancellations except in certain limited instances, including fraud.

A group plan or health insurer must provide at least 30 days advance written notice to the affected individual(s) before coverage may be rescinded.

Coverage for Preventive Care

A health plan must cover certain preventive services without cost-sharing. Cost-sharing includes deductibles, coinsurance, copayments, and similar charges. Cost-sharing does not include premiums or balance-billing amounts for non-network providers. This requirement will apply to new plans and existing plans that are not "grandfathered." It does not apply to existing plans that are "grandfathered" under the new law.[6]

---

[6] View the federal regulations on grandfathered plans at http://cciio.cms.gov/programs/marketreforms/grandfathered/index.html.

- **How This Affects Massachusetts**: Insurers in Massachusetts have historically been permitted to charge co-pays or other fees for preventive care, so this will be a new requirement. Draft regulations on the preventive services covered by the new law are available at www.healthcare.gov/center/regulations/prevention/regs.html.

Coverage for Older Children

Health plans must offer coverage for a child on a parent's health plan until the child reaches the age of 26, regardless of dependent status.

- **How This Affects Massachusetts**: In Massachusetts, prior to national health reform, health plans were already required to allow a child to be covered on a parent's plan until the child reached age 26 or two years after the child lost dependent status, depending on which came first.

Federal law does not require that a covered child's children be offered coverage on a parent's (grandparent's) employer-sponsored health insurance plan.

- **How This Affects Massachusetts:** In Massachusetts, a child of a covered dependent must be offered coverage on date of birth and thereafter, as long as the dependent is covered.

An older child will qualify for coverage under the federal law even if he or she is married, not living with a parent, is not a dependent on a parent's tax return, or is no longer a student.

The federal law provides an exception for grandfathered group plans. Federal law allows a grandfathered group plan to deny coverage to an adult child who is eligible for employer-sponsored insurance through his or her own employer.

- **How This Affects Massachusetts**: Massachusetts insurance laws do not allow for this exception to be applied to a fully insured plan.

IRS provisions in the federal law extend the general federal tax exclusion for reimbursements for medical care expenses under an employer-sponsored health plan to any child of an employee who has not attained age 27 as of the end of the taxable year.

- **How This Affects Massachusetts**: In Massachusetts, an employer will no longer need to determine imputed income for children covered under parents' employer-sponsored health insurance plans, including those children who had been covered for the two years after losing dependency status.

Even though children of covered employees must be offered coverage up to age 26, an employer may continue covering the child beyond his or her 26th birthday if permitted by the group insurance policy. For example:

- An employer's health plan will renew or expire by January 1.
- A child turned 26 in August, before January 1 and the start of a new plan year.
- The employer may allow that child to stay covered through the remaining months of the plan year if permitted by the group insurance policy.

In this example, the value of the child's benefits is excluded from the enrolled employee's income for the entire taxable year in which the child turned 26.

Coverage for Pre-existing Conditions

The new federal law prohibits the use of pre-existing condition exclusions against any individual beginning January 1, 2014 for plans sold or renewed on or after that date.

Plans sold or renewed on or after September 23, 2010, will be prohibited from allowing exclusions for pre-existing conditions for children under age 19.

- **How This Affects Massachusetts**: Massachusetts already prohibits health plans from denying health insurance coverage to anyone because of a pre-existing condition.

Before September 23, 2010, health plans were permitted to limit coverage of the specific pre-existing condition to new enrollees for up to six months if an enrollee received treatment for that specific condition in the previous six months, unless the enrollee has had continuous coverage. Under federal law, this will no longer be allowed for children under age 19 in 2010, and for anyone in 2014.

Effective Date

Except where noted, these changes are all effective for plans that are new or are renewed on or after September 23, 2010.

For More Information

- National Web Portal: http://www.healthcare.gov
- The Center for Consumer Information and Insurance Oversight: http://cciio.cms.gov/
- National Association of Insurance Commissioners and Center for Insurance Policy and Research: http://www.naic.org/index_health_reform_section.htm

7. Simple Cafeteria Plans

Simple cafeteria plans adopted by eligible small employers are deemed to comply with nondiscrimination rules applicable to cafeteria plans under section 125 of the Internal Revenue Code.

Section 125 plans (or "cafeteria plans") enable employees to tax savings when they purchase a health plan. A simple cafeteria plan is a plan sponsored by an eligible small employer that satisfies specified minimum eligibility, participation, and minimum employer contribution requirements. These plans are deemed to comply with the section 125 cafeteria plan nondiscrimination rules as well as the nondiscrimination requirements for life insurance, health plan and flexible spending account benefit options offered through the cafeteria plan.

As a result, eligible small employers save the time and administrative cost associated with conducting annual nondiscrimination testing.

Eligible Small Employer

An eligible small employer is an employer with an average of 100 or fewer employees during either of the preceding two years. An eligible small employer that establishes a simple cafeteria plan will remain eligible until its average number of employees reaches 200 or more.

Minimum Eligibility, Participation, and Contribution Requirements

Eligibility. Eligible employees are those who have worked at least 1,000 hours for the employer in the preceding year.

Participation. Once eligible, the employee may elect any benefit available under the plan, subject to any terms and conditions that are applicable to all plan participants.

Contributions. The employer must make a contribution on behalf of every non-highly paid employee eligible to participate in the plan whether or not the employee makes a salary reduction contribution.[7] The minimum employer contribution must be at least 2% of the employee's compensation, or not less than the lesser of 6% of the employee's compensation or twice the eligible employee's salary reduction contribution.

Effective Date

[7] The term "highly compensated employee" means any employee who (A) was a 5 percent owner at any time during the year or the preceding year, or (B) for the preceding year (i) had compensation from the employer in excess of $110,000 (for 2010), and (ii) if the employer elects the application of this clause for such preceding year, was in the top paid group of employees for such preceding year. An employee is in the top paid group of employees for any year if such employee is in the group consisting of the top 20 percent of the employees when ranked on the basis of compensation paid during such year.

Plan years beginning after December 31, 2010.

8. Changes to Health Savings, Flexible Spending, Medical Savings, and Health Reimbursement Accounts

There are new rules for health savings accounts, flexible spending accounts, medical savings accounts, and health reimbursement accounts.

Starting in 2011, a series of new federal rules for health savings accounts, flexible spending accounts, and health reimbursement accounts will take effect. Employers should communicate the new rules to employees in a clear and timely manner.

Over-the-Counter Medication

Over-the-counter drugs, with the exception of insulin, will not be eligible for reimbursement from a flexible spending account (FSA), health savings account (HSA), health reimbursement account (HRA), or Archer medical savings account (MSA), unless the drug is prescribed.

A drug is prescribed when there is a written or electronic order for the drug issued by a person legally authorized to write a prescription.

Originally, the IRS did not support the use of FSA and HRA debit card systems to purchase over-the-counter medicines purchased on or after January 16, 2011.[8] On December 23, 2010, the IRS released new guidance supporting continued use of FSA and HRA debit cards to purchase over-the-counter medications for which the individual has a prescription.[9]

Effective Date

Over-the-counter medications purchased on or after January 1, 2011, even if the money was set aside in an account-based plan in 2010.[10]

Withdrawal Penalties

The tax penalty for HSA withdrawals that are not used for qualified medical expenses will increase from 10% to 20%, and the tax penalty for unqualified withdrawals from Archer MSAs will increase from 15% to 20%.

Effective Date

January 1, 2011.

Maximum Salary Reduction for Flexible Spending Accounts

[8] IRS Notice 2010-59.
[9] IRS Notice 2011-5.
[10] IRS Notice 2010-59.

Beginning in tax year 2013, the maximum annual salary reduction contribution to an FSA will be capped at $2,500. If the plan does not specifically prohibit salary reductions in excess of $2,500, the *entire* FSA benefit will not receive a tax benefit.

Effective Date

January 1, 2013.

9. Employer Notice Requirement

Employers face new guidelines on reporting the value of health insurance coverage and providing employees with information regarding health insurance options.

W-2 Reporting

Employers must report the aggregate annual cost of employer subsidized health coverage on an employee's W-2. This requirement does not change the tax treatment of employer subsidized health coverage. Health coverage includes not only the group insurance plan, but also the cost of other employer-provided coverage including employee assistance programs, reimbursements from health reimbursement arrangements (HRAs), and employer contributions to health savings accounts (HSAs).

Effective Date

Although the law originally indicated that this reporting requirement would begin January 1, 2011, the IRS also announced that it will defer the new PPACA requirement for employers to report the cost of coverage under an employer-sponsored group health plan, making the reporting optional in 2011.[11] The Treasury Department and the IRS have determined that this relief is necessary to provide employers the time they need to make changes to their payroll systems or procedures in preparation for compliance with the new reporting requirement.

On October 12, 2010, the IRS issued a draft W-2 tax form for 2011 that employers can use to report wages and employee tax withholding.[12] The draft form W-2 includes the codes that employers may use to report the cost of coverage under an employer-sponsored group health plan.

The IRS provided further relief for smaller employers by making this reporting requirement optional for employers that file fewer than 250 W-2 forms until further guidance is issued.[13]

Although reporting the cost of coverage will be optional with respect for 2011, this does not imply that excludable employer-provided health care coverage will become taxable. The purpose of the optional report is simply to inform employees of the cost of their employer-provided health care coverage.

Exchange and Premium Tax Credit Notices

Employers must also provide employees written notice of:

[11] For more information see http://www.irs.gov/pub/irs-drop/n-2010-69.pdf.
[12] The draft form can be found at: http://www.irs.gov/pub/irs-utl/draft_w-2.pdf.
[13] Notice 2011-28. Available at http://www.irs.gov/pub/irs-drop/n-11-28.pdf.

- Beginning March 2013, the availability of the health insurance exchange to access insurance options and how the employee can contact the exchange for assistance.
- An employee's potential eligibility for federal assistance if the employer's health plan is "unaffordable" under the standards of the federal health reform law and/or if an employer offers a health plan valued at less than 60% of total costs.
- The risk of losing an employer contribution to health coverage if an employee purchases health insurance through the health insurance exchange.

Effective Date

March 1, 2013.

Summary of Benefits and Coverage

Health insurance issuers and plan sponsors of self-funded benefit arrangements will be required to provide a summary of benefits and coverage to applicants and enrollees in a culturally and linguistically appropriate manner.

The summary of benefits and coverage must not exceed four pages in length and must include information related to definitions of insurance terms; a description of the coverage; coverage exceptions, reductions, and limitations; cost-sharing provisions; renewability and continuation of coverage provisions; a coverage facts label that includes examples of common benefit scenarios; a statement of whether the plan provides minimum essential coverage and ensures that the plan covers at least 60% of total allowed costs; and a contact number.

Health insurance issuers and plan sponsors will also be required to notify enrollees no later than 60 days before material changes are made to the summary of benefits and coverage.

These requirements do apply to "grandfathered" plans.

Effective Date

Health insurance issuers and plan sponsors must begin providing a summary of benefits and coverage to applicants and enrollees no later than March 23, 2012. The Secretary of Health and Human Services is required to promulgate regulations on the summary of benefits and coverage by March 23, 2011. As of July 2011, regulations have not been promulgated.

10. Elimination of Deduction for Medicare Part D Subsidy

Employers will no longer be able to deduct the Medicare Part D retiree drug subsidy.

Medicare Part D provides a subsidy to businesses that cover prescription drugs for their retirees. The subsidy is 28 percent of allowable drug costs for retiree drugs costs between $250 and $1,000. Beginning in 2013, businesses will no longer be allowed to deduct prescription drug expenses that are covered by the Medicare Part D retiree drug subsidy.

The subsidy itself will not be eliminated, only the businesses' tax deduction of the subsidy.

Effective Date

January 1, 2013.

11. Medicare Payroll Tax

High-income workers will see a Medicare tax increase.

Beginning in 2013, there will be an additional 0.9% Medicare tax on individual filers whose earnings exceed $200,000 and joint filers whose earnings exceed $250,000. [14] The additional tax will only be imposed on the employee portion of the Medicare tax, not on the employer portion. Employers may wish to inform employees of this tax change as 2013 approaches.

Effective Date

January 1, 2013.

[14] Earned income refers to wages and self-employment income received with respect to employment.

12. Section 125 Plans

As of 2014, employees who buy insurance using a section 125 plan will not be eligible for pre-tax savings on plans sold through an exchange.

Under the new federal health reform law, employees will not be able to buy individual policies of health insurance through an exchange on a pre-tax basis using a section 125 plan. This rule does not apply to employees of small employers that offer employer-subsidized group health benefits through an exchange like Massachusetts' Health Connector.

Currently, Massachusetts law requires employers with 11 or more full-time-equivalent employees to establish section 125 plans. An eligible employee may use a section 125 plan to purchase an individual health insurance policy through the Health Connector using his or her own pre-tax earnings to pay 100% of the premium cost of a plan.

Massachusetts is seeking clarification on how the new federal requirement will interact with the current Massachusetts requirement.

Effective Date

January 1, 2014.

13. Assessment on Employers with 50 or More Full-Time Equivalent Employees

Large employers with 50 or more FTEs may face a federal assessment.

Employers with 50 or more FTEs may be subject to assessment if:

- Any full-time employee receives premium tax credits to purchase health insurance through an exchange. Employees become eligible for credits if:
    - Their premium contribution for the employer-sponsored coverage would cost them more than 9.5% of their household income, or the actuarial value of the employer plan is less than 60%;[15] and
    - Their household income is below 400% of the federal poverty level.

The assessment can affect employers that do not offer coverage, as well as those that do (although assessment amount will vary).

Employers with 50 or more full-time equivalent employees (FTEs) that *do not offer* minimum essential coverage[16]

If at least one full-time employee enrolls in an exchange plan and receives a premium tax credit, the employer will be assessed $2,000 ($167 per month) for each full-time employee on payroll, excluding the first 30 full time employees.

Employers with 50 or more FTEs that *do offer* minimum essential coverage

If at least one full-time employee enrolls in an exchange plan and receives a premium tax credit, the employer will pay the lesser of:

- $3,000 ($250 per month) for each full-time employee enrolled in the exchange and receiving a premium credit, or
- $2,000 ($167 per month) for each full-time employee on payroll, excluding the first 30 full-time employees.

These penalties are not deductible by the employer.

---

[15] Actuarial value measures the share of the medical expenses covered by the insurance plan.

[16] "Minimum essential coverage" is coverage required to fulfill the individual mandate and includes coverage under Medicare part A, Medicaid, the Children's Health Insurance Program (CHIP), Tricare, the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Secretary of the Department of Health and Human Services in coordination with the Treasury Secretary.

Premium Tax Credits

An employee becomes eligible for a premium tax credit if the employee's household income is below 400% FPL and:

- The employee is not offered insurance through an employer or is offered a plan with an actuarial value of less than 60%, or
- The employee must pay more than 9.5% of household income toward the premiums of an employer's plan.

Who is a Full-Time Employee?

Under federal health reform, a full-time employee works 30 or more hours per week for the employer. This varies from the current Massachusetts standard under the Fair Share requirement of "the lesser of 35 hours per week or the number of hours required to be eligible for the same level of employer contribution that is offered to full-time employees working at least 35 hours per week."

The $2000 and $3000 federal annual penalty assessments are determined using the number of full-time employees. Massachusetts officials are currently trying to determine how to resolve this difference so as to make it clearer and easier for Massachusetts employers.

Who is a Full-Time Equivalent Employee?

Under both federal and Massachusetts health reform, the full-time equivalent employee (FTE) measure is used ONLY to determine if the employer meets the FTE threshold to be subject to the assessment rules. Under federal health reform, an employer's FTEs would include all full-time employees working 30 or more hours per week for the employer, PLUS the aggregate number of hours worked by part-time employees for the month divided by 120. Under Massachusetts health reform, an employer's FTEs is calculated by adding the payroll hours of every employee during a calendar quarter and dividing the total payroll hours by 500.

Comparing the Massachusetts and Federal Employer Assessments

Massachusetts health reform currently requires an employer with 11 or more FTEs to make a "fair and reasonable" contribution towards the costs of covering their workers. If it does not, it may be liable for a $295 per FTE per year penalty.

To avoid the Massachusetts assessment, an employer with **11-50 FTEs** must:

- Offer their full-time employees at least a 33% of premium contribution for individual coverage no later than 90 days after date of hire.

  OR

- Have at least 25% of their full-time employees enrolled in a group health plan.

To avoid the Massachusetts assessment, employers **with 50 or more FTEs** must:

- Offer their full-time employees at least a 33% premium contribution for individual coverage no later than 90 days after their date of hire **AND** have 25% or more of full-time employees participating in a group health plan
  OR
  Have at least 75% of their full-time employees participating in the group health plan

Massachusetts officials are working to resolve the differences between the state and federal standards. This guide will be updated and outreach conducted as decisions are reached.

Massachusetts Fair Share Contribution and the PPACA Employer Assessment

	Massachusetts (FSC)	**Federal (PPACA)**
Applicability	Firms with 11 or more FTEs	Firms with 50 or more FTEs
Standards for Avoiding Assessment	33% employer premium contribution 25% of full-time employees enrolled in group plan[17]	Offer Minimum Essential Coverage. Employee use of premium tax credits.
Assessment Amount	Fine of $295 per FTE. Funds accrue to the Commonwealth Care Trust Fund.	Fine between $2,000 and $3,000 per full-time employee. Excludes first 30 employees in some cases. Funds accrue to the US Treasury.

Effective Date

January 1, 2014.

[17] Employers with 11-49 FTEs can meet either standard to avoid assessment. Employers with 50 or more FTEs must meet both standards or demonstrate enrollment of at least 75% in its group health plan among full-time employees.

14. The Small Business Health Options Program

Small businesses will be able to purchase health insurance for their employees through an exchange.

The federal health reform law creates state exchanges to help individuals and small businesses buy health insurance. Small employers may purchase group health insurance for their employees through an exchange.

Massachusetts small businesses already have access to similar services through the Health Connector. The federal health reform law will create exchanges to provide those services in all states.

In 2014, small business tax credits for health insurance coverage will only be available for small group coverage purchased exclusively through an exchange. Please refer back to the Section 1 of this guide, for more information on the small business tax credit.

Massachusetts currently allows small business with fewer than 50 full-time employees to purchase a group health plan through its exchange, the Health Connector. In contrast, the federal health reform law will allow employers with fewer than 100 employees to participate in exchanges, though states may choose to limit exchange participation to employers with fewer than 50 employees. However, the lower state limit cannot extend past 2015.

Effective Date

January 1, 2014.

15. Excise Tax on High Cost Coverage

High cost employer-sponsored health plans will be subject to a tax.

There will be an excise tax on employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage.

A 40% tax will be imposed on the coverage provider for the value of the "excess benefit," or the health coverage that exceeds the threshold amount. [18] The threshold amount is $10,200 for an individual health insurance plan and $27,500 for a family plan. These amounts will be adjusted to account for various factors such as if health care costs increase more than expected.

Effective Date

January 1, 2018.

[18] The "coverage provider" could be an insurer, employer, or a plan administrator.

PPACA Employer-Related Provision Implementation Timeline

Provision	*Brief Description*	*Effective Date*
Small Business Tax Credits	Credits to help small businesses with low and middle-income workers pay for the cost of health insurance.	Tax year 2010
Grants for Small Employer Wellness Programs	Funding to help small businesses offer programs to keep employees healthy.	Immediately; grant money is available for 2011-2015
Early Retiree Reinsurance Program	Employers may receive financial assistance to help pay for expensive medical costs of early retirees.	June 1, 2010-January 1, 2014 (may end earlier if funding expires)
Reasonable Break Time and Space for Nursing Mothers	Employers must offer adequate break time and space for breastfeeding workers.	Immediately
Automatic Enrollment in Health Insurance for Large Firms	Large employers that offer health coverage must automatically enroll new full-time employees in a plan.	Effective upon issuance of guidance by the Department of Labor
Insurance Reforms	Various consumer protections go into effect.	Some start on September 23, 2010; others in future years.
Simple Cafeteria Plans	Simple cafeteria plans adopted by small employers will be deemed to comply with IRS nondiscrimination rules.	January 1, 2011
Changes to Health Savings Accounts, Flexible Spending Accounts, Medical Savings Accounts, and Health Reimbursement Accounts	Health savings accounts, flexible spending accounts and health reimbursement accounts are subject to new rules.	2011-2013
Employer Notice Requirement	Employers face new guidelines on reporting the value of health plans and providing employees with information regarding health insurance options.	2011-2013

Provision	*Brief Description*	*Effective Date*
Eliminate Deduction for Medicare Part D Expenses	The employer's deduction for the amount of the Medicare Part D retiree drug subsidy will be eliminated.	2013
Medicare Payroll Tax	High-income employees will pay an increased Medicare tax.	2013
Section 125 Cafeteria Plans	Employers buying insurance with Section 125 plans will no longer be able to purchase plans through an exchange with pre-tax dollars.	2014
Assessment for Employers with 50 or More Full-Time Equivalent Employees	Large employers will face an assessment if employees access premium tax credits. An employee becomes eligible if wages are under 400% FPL and the employer offers no coverage or offers coverage that is unaffordable.	2014
Small Business Health Options Program	Eligible small businesses will only be able to receive tax credits to purchase insurance through the newly-created exchange.	2014
High Cost Plan Tax	Insurers of employer-sponsored health plans will be subject to a tax on high-cost health plans.	2018